TCC COVID-19 HEALTH SCREENING

	NAME (First & Last)	**DATE**	**__/__/__**
		NO	**YES**
1.	Do you have a fever of 100.4 F or greater?		
2.	Do you have any of the following symptoms not associated with existing medical conditions: a. Shortness of breath b. New Cough c. Excessive Chills d. Severe Muscle Pain e. Loss of Taste or Smell f. New Profound Headache		
3.	In the last 14 days, have you traveled to or from a high risk COVID-19 state or country for personal reasons, other than work or school, or have you been exposed to anyone known to be positive for COVID-19? (This excludes healthcare workers exposed while wearing recommended PPE).		
	TCC Volunteer Initials -		

If someone answers yes to Question #1-2, they should be asked to return home with a recommendation to call their doctor.

If someone answers yes to Question #3, please call Scott, Jim C., Stan, Don K., Jim R., or Jennifer for further instructions.